



## Structural Racism and Supporting Black Lives — The Role of Health Professionals

Rachel R. Hardeman, Ph.D., M.P.H., Eduardo M. Medina, M.D., M.P.H., and Katy B. Kozhimannil, Ph.D., M.P.A.

**O**n July 7, 2016, in our Minneapolis community, Philando Castile was shot and killed by a police officer in the presence of his girlfriend and her 4-year-old daughter. Acknowledging

the role of racism in Castile's death, Minnesota Governor Mark Dayton asked rhetorically, "Would this have happened if those passengers [and] the driver were white? I don't think it would have." Such incidents are tragic — and disturbingly common. Indeed, in recent weeks, our country has witnessed the well-publicized deaths of at least three more black men at the hands of police: Terence Crutcher, Keith Scott, and Alfred Olango.

Disproportionate use of lethal force by law-enforcement officers against communities of color is not new, but now we increasingly have video evidence of the traumatizing and violent experiences of black Americans. Structural racism — a confluence of institutions, culture, history, ideology, and codified practices that generate and perpetuate inequity among racial and ethnic groups<sup>1</sup> — is the common denominator of the violence that is cutting lives short in the United States.

The term "racism" is rarely used

in the medical literature. Most physicians are not explicitly racist and are committed to treating all patients equally. However, they operate in an inherently racist system. Structural racism is insidious, and a large and growing body of literature documents disparate outcomes for different races despite the best efforts of individual health care professionals.<sup>2</sup> If we aim to curtail systematic violence and premature death, clinicians and researchers will have to take an active role in addressing the root cause.

Structural racism, the systems-level factors related to, yet distinct from, interpersonal racism, leads to increased rates of premature death and reduced levels of overall health and well-being. Like other epidemics, structural racism is causing widespread suffering, not only for black people and other communities of color but for our society as a whole.<sup>2</sup> It is a threat to the physical, emotional, and social well-being of every person in a society that allocates privilege on the basis of race.<sup>3</sup> We

believe that as clinicians and researchers, we wield power, privilege, and responsibility for dismantling structural racism — and we have a few recommendations for clinicians and researchers who wish to do so.

First, learn about, understand, and accept the United States' racist roots. Structural racism is born of a doctrine of white supremacy that was developed to justify mass oppression involving economic and political exploitation.<sup>3</sup> In the United States, such oppression was carried out through centuries of slavery premised on the social construct of race.

Our historical notions about race have shaped our scientific research and clinical practice. For example, experimentation on black communities and the segregation of care on the basis of race are deeply embedded in the U.S. health care system.<sup>4</sup> Disparate health outcomes and systematic inequalities between black Americans and white Americans in terms of wealth, well-being, and quality of life must be seen as extensions of a historical context in which black lives have been devalued. We would argue that health care professionals have an individual and a collective responsibility to

understand the historical roots of contemporary health disparities.

Second, understand how racism has shaped our narrative about disparities. Researchers and clinicians have long used rhetoric implying that differences between races are intrinsic, inherited, or biologic. Pre-Civil War physicians attributed poor health among slaves to their biologic inferiority rather than to their conditions of servitude.<sup>4</sup> Such beliefs persist today: a study published earlier this year revealed that 50% of white medical students and residents hold false beliefs about biologic differences between black and white people (e.g., black people's skin is thicker; black people's blood coagulates more quickly).<sup>5</sup> Implicit bias and false beliefs are common — indeed, we all hold them — and it's incumbent on us to challenge them, especially when we see them contributing to health inequities.

Third, define and name racism. In health care and health services research, we need consistent definitions and accurate vocabulary for measuring, studying, and discussing race and racism and their relationships to health. Armed with historical knowledge, we can recognize that race is the “social classification of people based on phenotype” — “the societal box into which others put you based on your physical features,” as Camara Jones of the National Center for Chronic Disease Prevention and Health Promotion puts it. Racism, Jones continues, “is a system of structuring opportunity and assigning value based on phenotype (race) that: unfairly disadvantages some individuals and communities; unfairly advantages other individuals and communities; [and] undermines realization of the full potential of the whole society through the waste of human re-

sources.”<sup>1</sup> If we acknowledge and name racism in our work, writing, research, and interactions with patients and colleagues, we can advance understanding of the distinction between racial categorization and racism and clear the way for efforts to combat the latter.

To pursue those efforts, we will have to recognize racism, not just race. We frequently measure and assess differences according to race. Patients check race boxes on forms; clinicians and health systems may assess racial differences in care; and researchers include race as a variable in regression models. When a person's race is ascertained and used in measurement, is it merely an indicator for race, or does it mask or mark racism? For example, race is often used as an input in diagnostic algorithms (e.g., for hypertension or diabetes), which may deflect attention from underlying causes — beyond biology — that may be contributing to the medical condition. Black Americans, on average, have more poorly controlled diabetes and higher rates of diabetes complications than white Americans. Successful treatment of such chronic conditions requires attention to structural factors and social determinants of health, but antiracism strategies are rarely recommended for improving diabetes control. Perhaps if we shift our clinical and research focus from race to racism, we can spur collective action rather than emphasizing only individual responsibility.

Finally, to provide clinical care and conduct research that contributes to equity, we believe it's crucial to “center at the margins” — that is, to shift our viewpoint from a majority group's perspective to that of the marginalized group or groups. Historical and contemporary views of economics,

politics, and culture, informed by centuries of explicit and implicit racial bias, normalize the white experience. In describing Castile's death, for example, Governor Dayton noted that the tragedy was “not the norm” in our state — revealing a deep gap between his perception of “normal” and the experiences of black Minnesotans.

Centering at the margins in health care and research will require re-anchoring our academic and health care delivery systems — specifically, diversifying the workforce, developing community-driven programs and research, and helping to ensure that oppressed and underresourced people and communities gain positions of power. Centering at the margins in clinical care and research necessitates redefining “normal.” We can do so by using critical self-consciousness — the ability to understand how society and history have influenced and determined the opportunities that define our lives. For clinicians, that means reflecting on how they arrived at their understanding of a diagnosis or clinical encounter and being willing to understand how patients arrived at theirs. Centering at the margins not only provides an important opportunity to practice more patient-centered care but can also generate new findings and clinical insights about the experiences of people who are often overlooked or harmed by our institutions.

We believe that in Minnesota and throughout the country, health care professionals have an obligation and opportunity to contribute to health equity in concrete ways. Addressing violence against black communities can start with anti-racist practices in clinical care and research. Do we have the courage and conviction to fight to ensure that black lives do indeed matter?

Disclosure forms provided by the authors are available at [NEJM.org](http://NEJM.org).

From the Division of Health Policy and Management, University of Minnesota School of Public Health (R.R.H., K.B.K.), and the Park Nicollet Clinic (E.M.M.) — both in Minneapolis.

This article was published on October 12, 2016, at [NEJM.org](http://NEJM.org).

1. Jones CP. Confronting institutionalized racism. *Phylon* 2002;50:7-22.
2. Gee GC, Ford CL. Structural racism and health inequities: old issues, new directions. *Du Bois Rev* 2011;8:115-32.
3. Bonilla-Silva E. White supremacy and racism in the post-civil rights era. Boulder, CO: Rienner, 2001.
4. Cunningham BA. Race: a starting place. *Virtual Mentor* 2014;16:472-8.

5. Hoffman KM, Trawalter S, Axt JR, Oliver MN. Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proc Natl Acad Sci USA* 2016;113:4296-301.

DOI: 10.1056/NEJMp1609535

Copyright © 2016 Massachusetts Medical Society.

## Permanent Supportive Housing for Homeless People — Reframing the Debate

Stefan G. Kertesz, M.D., Travis P. Baggett, M.D., M.P.H., James J. O'Connell, M.D., David S. Buck, M.D., M.P.H., and Margot B. Kushel, M.D.

The persistence of homelessness in the United States has increased interest in providing permanent housing with supportive services to people with disabling conditions who have been homeless for more than a year. Skeptical about achieving political consensus on providing housing solely on humanitarian grounds, advocates for ending homelessness have increasingly turned to a financial argument, claiming that permanent supportive housing will deliver net cost savings to society by reducing the use of jails, shelters, and hospitals. But as researchers and clinicians who endorse such permanent supportive housing, we believe the cost-savings argument is problematic and that it would be better to reframe the discussion to focus primarily on the best way to meet this population's needs.

The Department of Housing and Urban Development estimated that more than 500,000 people in the United States were homeless in January 2015, about one seventh of them chronically homeless (see graph).<sup>1</sup> The deprivations of homelessness, recognized as early as the Genesis story of Cain, are revealed starkly in contemporary research. Homeless people have higher rates of premature death,

a greater burden of acute and chronic physical health conditions, a higher prevalence of psychiatric and addictive disorders, and a higher risk of being sexually or physically assaulted than do people who have a home. Although delivery of health care services represents one component of a comprehensive response to homelessness, the growing recognition of housing as a social determinant of health calls for solutions that will prevent and end homelessness.

In 2010, the U.S. government endorsed the Housing First approach to permanent supportive housing as the preferred solution for chronic homelessness. Whereas other programs require people to engage in psychiatric or substance use treatment and attain stability and sobriety before they can receive housing, Housing First offers permanent supportive housing without these prerequisites. This approach bundles financial support for housing with offers of psychiatric, medical, and social rehabilitative support. Some Housing First programs use a “scattered site” model, providing subsidized rental support for a private-market apartment coupled with outreach from clinicians and social workers who regularly visit the tenant and assist as needed. Other pro-

grams use a “project-based” model, accommodating formerly homeless tenants in a building where comprehensive psychosocial services are available.

Studies in the United States and Canada have shown that Housing First interventions result in faster exits from homelessness and more time spent in housing than do traditional approaches.<sup>2</sup> But fearing that reducing chronic homelessness would not prove sufficient to persuade policymakers or the public to invest in these programs, many advocates have sought to demonstrate cost savings. Anecdotal evidence, analyses using pre-post designs, and a high-profile quasi-experimental study of Housing First for high-cost homeless people with alcohol use disorders offered the possibility of transcending political divides by suggesting that Housing First could save more money than it costs.<sup>3</sup> This notion gained traction through lay-media articles based largely on unpublished, noncontrolled studies and on anecdotal reports such as Malcolm Gladwell's “Million-Dollar Murray” (<http://www.newyorker.com/magazine/2006/02/13/million-dollar-murray>).

Higher-quality randomized, controlled trials, however, haven't demonstrated net cost savings.<sup>4</sup>